

# Risk assessment in the Netherlands

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# International Perspectives on Violence Risk Assessment

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## Risk Assessment in the Netherlands

*Corine de Ruiter*

This chapter reviews the history and current state of affairs concerning risk assessment in the Netherlands, with a particular emphasis on the adult forensic mental health system and the Terbeschikkingstelling (TBS) order. The role of risk assessment in the probation service, outpatient forensic settings, and adolescent forensic psychiatry is also discussed briefly. Dutch forensic mental health professionals belong to the “early adopters” of structured risk judgment (SPJ) tools, which has led to their prolific use but possibly also to some inadvertent side effects. Recently, Dutch researchers have developed structured tools for the assessment of protective factors (e.g., Structured Assessment of PROtective Factors [SAPROF]; de Vogel, de Ruiter, Bouman, & de Vries Robbé, 2009) to complement the assessment of risk factors, which fits well within the tradition of humane and rehabilitative treatment of mentally disordered offenders in the Netherlands.

### The Dutch Legal Framework

The Dutch Entrustment Act (in Dutch: Beginselenwet verpleging ter beschikking gestelden of 1997), was originally enacted in 1928 (van Marle, 2002). Its goal was to protect society from individuals who had committed a serious crime on account of a serious mental disorder or defective development (including a personality disorder or serious intellectual disability), and who were believed to constitute a continuing danger to society. In general, a TBS order is combined with mandatory treatment (Art. 37b, §1 Dutch Code of Criminal Law [CCL]). The law requires that at least two experts from

different disciplines report on the defendant before the trial court can issue a TBS order. A judge can impose a TBS order if the following conditions apply (Art. 37a CCL): (a) the defendant must suffer from a mental disorder, which means his responsibility for the alleged crime is (severely) diminished or absent; (b) the crime carries a prison sentence of at least 4 years, and (c) there is a risk for the safety of other people or for the general safety of persons or goods.

A TBS order results in involuntary admission to a specialized maximum-security forensic psychiatric hospital (Art. 37d, §1 CCL) aimed at motivating the patient to participate in the hospital's treatment programs. Forensic patients detained under TBS legislation in general have been convicted for serious violent and sexual offenses (for further discussion of the TBS system, see de Ruiter and Hildebrand [2003] and de Ruiter and Petrila [2016]).

The Netherlands has a dualistic sanctioning system. Punitive sanctioning takes place when a defendant is considered guilty of the crime and is also deemed culpable. Coercive measures, such as the TBS order, can be used when the defendant is guilty and also considered high risk and not fully culpable. The choice between punishment and coercive measures is determined by the judge, based on the degree of responsibility of the defendant. Article 37a of the CCL creates the possibility of diminished responsibility. On the basis of this legal statute, more refined "degrees" of criminal responsibility were introduced in the Dutch jurisprudence and, eventually, a 5-point scale emerged that indicates the degree of criminal responsibility: full responsibility, slightly diminished responsibility, diminished responsibility, severely diminished responsibility, and total absence of responsibility. For example, if a person committed a first-degree murder while experiencing an episode of paranoid psychosis and the trial court consequently considers this person to have diminished responsibility for the offense, the court can sentence him to a long (e.g., 15 years, which is considered long in the Netherlands) prison sentence in combination with a TBS order. In this case, the prison sentence is executed first; after the prison term is served, the person is transferred to a forensic hospital. In theory, and sometimes also in practice, a person found guilty but with diminished responsibility can serve the same prison term as a fully responsible defendant and face an additional period of involuntary hospitalization beyond the prison term. Common-law systems in general have fewer "degrees" of criminal responsibility. Also, in contrast to common-law systems, a diminished degree of responsibility in the Dutch legal system is not restricted to a list of sanctioned diseases and disorders. Thus, antisocial personality disorder may be a reason for diminished responsibility in the Netherlands (de Ruiter & Petrila, 2016).

All 13 Dutch forensic psychiatric hospitals that admit TBS patients use a cognitive-behavioral approach to treatment. Patients live in a secure setting, with units housing around 12 patients. Whenever possible, from a risk management perspective, patients are allowed a degree of freedom of movement inside the hospital. During the first 8 weeks after admission, a structured

violence risk assessment is conducted for every patient, using validated risk assessment tools such as the Historical–Clinical–Risk Management 20 and the Sexual Violence Risk-20. A treatment and risk management plan that focuses on diminishing dynamic risk factors for violence is formulated. For patients with personality disorders, these factors may include impulsivity, lack of empathy, deficient coping skills, and hostile and/or antisocial attitudes. For patients with psychotic disorders, risk factors may include delusions and hallucinations, a lack of insight into their illness, and problems with substance use (de Ruiter & Petrila, *in press*).

### History of Violence Risk Assessment in the Netherlands

Structured violence risk assessment tools were introduced into the Dutch forensic mental health system during the late 1990s (de Ruiter & Hildebrand, 2003, 2007). Before then, risk assessments were performed on the basis of unstructured clinical judgment, which have been shown to be unreliable and invalid, also within the Dutch TBS context (de Vogel, de Ruiter, Hildebrand, Bos, & van de Ven, 2004; Philipse, Koeter, van der Staak, & van den Brink, 2006). Tools stemming from the SPJ approach have dominated Dutch forensic psychiatry from the start, because these tools contain dynamic risk factors and are, thus, suitable to measure changes in risk level, in contrast to actuarial tools, which consist mostly of static, historical risk factors. Requests for extension of liberties, such as supervised or unsupervised leave for forensic patients under the TBS order, have to be forwarded to the Ministry of Justice. Since January 1, 2008, all requests for leave are examined by the Leave Review Advisory Board (in Dutch, Adviescollege Verloftoetsing [AVT]). It consists of at least nine forensic psychologists/psychiatrists, at least three jurists, and one scientific advisor on risk assessment. The request to the AVT has to be submitted according to a set format that includes strict guidelines concerning the use of structured risk assessment tools and reporting (see Box 18.1).

Theoretically, a TBS order is of indefinite duration (Article 38e, §2 CCL). Initially imposed for 2 years (Article 38d, §1 CCL), it may be extended for 1- or 2-year periods as the court reevaluates the patient to determine whether the risk to society is still too high (Article 38d, §2 CCL). Forensic hospitals base their advice to the court on the extension (or termination) of the TBS order by means of structured risk assessments, highly similar to the requests made to the AVT. The typical progression of patients under the TBS order is from supervised to unsupervised leave, leading up to the “transmural” phase. During transmural leave, the patient lives outside the hospital but is still closely supervised by hospital staff. Structured risk assessments are conducted at each point an extension of the patient’s liberties is contemplated; in case no extension is foreseen, risk assessments need to be repeated at least every 6 months. If the patient breaches a condition, he or she may be recalled

**Box 18.1 Risk Assessment in Requests for Leave for Forensic Psychiatric Patients under Terbeschikkingstelling Law**

Risk assessment has to be performed by means of evidence-based instruments such as the Historische, Klinische, Toekomstige-30 (HKT-30), the Historical–Clinical–Risk Management<sup>20</sup>, the Sexual Violence Risk-20, and the Psychopathy Checklist—Revised. The HKT-30 is a structured risk assessment tool that was developed in the Netherlands. It consists of 30 items (11 historical, 13 clinical and dynamic, and 6 future) scored on a 5-point scale (Werkgroep Risicotaxatie Forensische Psychiatrie, 2002). A multidisciplinary consensus on the interpretation and weighing of risk is important. Furthermore, specific attention needs to be paid to the following combination of risk items of the HKT-30: impulsivity, substance use, attitudes toward intervention, hostility, violation of conditions, social skills, and coping skills. It is mandatory to follow the manuals of the mentioned instruments. This means, for instance, that items must be judged in relation to their interaction with other items. The document should explain how risk will be managed toward an acceptable level via a risk management plan. When a high degree of psychopathy is present (i.e., a score of 26 points or more on the Psychopathy Checklist—Revised), a description of the underlying factors is required.

to the hospital. Reintegration into society is gradual and the patient is assisted in finding work and leisure activities, and building a social network. The usual road to termination of the TBS order is via conditional discharge, with supervision from the probation service. Since September 2010, the conditional phase can last up to 9 years (de Ruiter & Petrila, in press).

**Inadvertent Effects of Structured Risk Assessment**

Since the implementation of structured risk assessment instruments in the Dutch forensic mental health system, the average duration of the treatment phase under the TBS order has increased from 4.2 years for those terminated in 1990 to 8.4 years in 2008 (Nagtegaal, van der Horst, & Schönberger, 2011).

Nagtegaal et al. (2011) offer a number of plausible explanations for this development, although a causal relationship can obviously not be inferred. Dutch society in general has become more risk averse and “tough on crime” in recent decades (Boutellier, 2005). Also, in 2004 and 2005, several cases of TBS patients who committed serious offenses during granted leaves received extensive media coverage, and this resulted in repeated critical debates in parliament about the workings of the TBS system. In 2005, the Parliamentary Committee Visser was installed with the task of investigating how the TBS

system could be improved to safeguard society against mentally disordered offenders. The report of the Committee Visser (2006) contained 17 recommendations for improvement, a number of which were related to stricter release decision making, which ultimately resulted in the creation of the AVT in 2008.

The use of structured risk assessment instruments is subject to a number of shortcomings. These instruments have been tested empirically at the group level, but a number of scholars have argued they are not actually well suited to predict reoffending at the individual level (Cooke & Michie, 2011; Hart, Michie, & Cooke, 2007; Singh, Fazel, Gueorguieva, & Buchanan, 2014). "High risk" has been shown to have a different meaning, in terms of the objective probability of recidivism, in different samples (Singh et al., 2014). "High," "moderate," and "low" risk most probably also have varying meanings for different mental health professionals and for different legal decision makers (see, for example, Hilton, Carter, Harris, and Sharpe [2008]). Furthermore, most forensic mental health professionals in the Netherlands receive one-time, on-the-job training in the use of risk assessment tools, without any continuing education (Nagtegaal et al., 2011).

### Risk Assessment in Other Forensic Settings

A number of other forensic fields in the Netherlands have implemented structured risk assessment tools, largely as a result of the adoption of the risk-need-responsivity model (Andrews & Bonta, 2003) by the Ministry of Justice during the late 1990s. For offender rehabilitation to be consistent with the risk-need-responsivity model, knowledge of the offender's risk level and criminogenic needs is essential (e.g., Andrews & Bonta, 2003; Ogloff & Davis, 2004). The Dutch Probation Service commissioned the development of a new risk assessment tool titled the Recidive Inschattingsschalen (Recidivism Assessment Scales, or RISC; Adviesbureau Van Montfoort & Reclassering Nederland, 2004) that fulfilled the twin goals of allowing more integrated services between prison and probation staff while also ensuring all probation officers assessed risk in the same manner. The aim of the RISC is to provide a common, efficient, and effective offender risk and needs assessment system that enables the prison and probation service to achieve targets for reduction in reoffending/reconviction rates, and to provide increased protection to the public. Several studies of the reliability (van der Knaap, Leenarts, Born, & Oosterveld, 2012) and predictive validity for general recidivism (van der Knaap & Alberda, 2009) of the RISC have been conducted. Most recently, Hildebrand, Hol, and Bosker (2013) demonstrated that a selection of only 17 items from the total 61 RISC items was sufficient to predict probation violation (area under the curve [AUC] = .73).

Another risk assessment instrument used by the Dutch Probation Service and by several outpatient (forensic) mental health clinics is the Brief Spousal



Assault Form for the Evaluation of Risk (B-SAFER; Kropp, Hart, & Belfrage, 2005). The implementation of the B-SAFER resulted from the finding that the RISC did not predict adequately intimate partner violence reoffending in a sample of 100 probationers, whereas the B-SAFER did (Reclassering Nederland, 2012) (. Subsequent studies have documented the relevance of the B-SAFER in determining subtypes of spousal assaulters in both probation and general mental health settings (Serie, van Tilburg, van Dam, & de Ruiter, 2015; Thijssen & de Ruiter, 2011).

Violence risk assessment instruments have also been implemented systematically in the Dutch juvenile forensic mental health system. More specifically, the Structured Assessment of Violence Risk in Youth (Borum, Bartel, & Forth, 2002) is the instrument of choice when juvenile justice institutions prepare a request to the Ministry for an increase of liberties for a juvenile (Ministry of Justice, 2014). In a study of 117 violent juvenile offenders, we found that unstructured clinical judgment predicted violent reoffending at 3-years of follow-up at a chance level ( $AUC = .45$ ) whereas the Structured Assessment of Violence Risk in Youth summary risk judgment showed significant predictive accuracy ( $AUC = .71$  [Lodewijks, Doreleijers, & de Ruiter, 2008]).

Although risk assessment tools have taken a prominent position in the management of risk for those individuals who have already been sentenced, the use of these tools in presentencing forensic mental health evaluations is still highly dependent on the mental health expert who performs the evaluation. A recent study of the quality of pretrial forensic mental health reports on juveniles from the years 2005 to 2007 (Duits, van der Hoorn, Wiznitzer, Wettstein, & de Beurs, 2012) showed a standardized quality rating of around 6 points on a scale from 1 to 10 points, with one of the shortcomings being insufficient information on risk assessment and management.

### Recent Developments and Future Outlook

The implementation of structured risk assessment tools in the Dutch forensic mental health system during the late 1990s met with some hesitation and, sometimes, even outright resistance from clinical staff. Their reluctance was echoed in a thought-provoking paper by Rogers (2000), who claimed that an overreliance on risk factors could result in pessimism among therapists, stigmatization of offenders/patients, and, ultimately, in a too-lengthy detention of forensic psychiatric patients. At about the same time, we started to develop a new tool for protective factors (i.e., SAPROF [de Vogel et al., 2009]) to enhance the assessment of risk of future (sexually) violent behavior with instruments such as the Historical-Clinical-Risk Management-20 and Sexual Violence Risk-20. The SAPROF is divided into three subscales: internal items, motivational items, and external items. Initial

studies have shown good predictive validity of the SAPROF for desistance from violence after discharge from clinical treatment in TBS patients at short- to medium-term follow-up (1-year AUC = .85, 3-year AUC = .75) as well as at long-term follow-up (11-year AUC = .73) (de Vries Robbé, de Vogel, & de Spa, 2011). Independent studies conducted in the United Kingdom found that the SAPROF was able to predict inpatient violence (AUC = .85) and self-harm (AUC = .77) (Abidin et al., 2013), as well as discharge from forensic psychiatric treatment (AUC = .81) (Davoren et al., 2013). The Short-Term Assessment of Risk and Treatability (START; Webster, Martin, Brink, Nicholls, & Desmarais, 2009) is another instrument that contains protective or strength factors that has been implemented successfully in Dutch forensic psychiatry. The START is intended for short-term risk assessment (days to months) and treatment planning for diverse adverse outcomes (suicide, self-harm, violence, substance abuse, self-neglect, victimization) that can arise when caring for individuals with mental disorders. The START comprises 20 items, each evaluated concerning their strength and vulnerability property for the actual person. Troquete et al. (2015) found support for the predictive validity of the START in outpatient forensic psychiatry at 3 months and 6 months follow-up, although AUC values were lower than those found in previous studies with the START in inpatient and research settings (e.g., Wilson, Desmarais, Nicholls, & Brink, 2010).

Evidently, structured risk assessment tools—and SPJ instruments in particular—have gained a prominent position in Dutch forensic mental health services during the past decade. Furthermore, a strong tradition of empirical validation research on violence risk assessment has emerged in the Netherlands. Dutch scholars have also been leading in the development of novel risk assessment tools, such as the SAPROF and the Female Additional Manual (de Vogel, de Vries Robbé, van Kalmthout, & Place, 2011). This has formed a strong foundation to move on to new research questions and new paradigms beyond psychometric predictive validity studies. Studies into the effectiveness of risk management strategies based on structured risk assessment instruments are still scarce (de Ruiter & Nicholls, 2011), as are studies of the most effective ways of risk communication (for an overview of this literature, see de Ruiter and Kaser-Boyd [2015]). Future innovative research in the Netherlands and abroad will hopefully bring the use of structured risk assessment tools to the next level.

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